Exhibit 41

HIGHLY CONFIDENTIAL - ATTORNEYS' EYES ONLY

IN THE UNITED STATES DISTRICT COURT

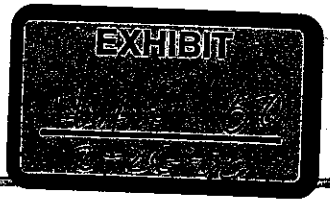
FOR THE DISTRICT OF MASSACHUSETTS

In Re: PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION	)
THIS DOCUMENT RELATES TO ALL ACTIONS	)

October 6, 2004

12:23 p.m.

Deposition of CHRISTOPHER EDDY, held at the offices of Morgan, Lewis & Bockius LLP, 101 Park Avenue, New York, New York, pursuant to subpoena, before Cary N. Bigelow, RPR, a Notary Public of the State of New York.



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EXHIBITS

IT IS HEREBY STIPULATED AND AGREED, by and between the attorneys for the respective parties herein, that filing and sealing be and the same are hereby waived.

IT IS FURTHER STIPULATED AND AGREED that all objections, except as to the form of the question, shall be reserved to the time of the trial.

IT IS FURTHER STIPULATED AND AGREED that the within deposition may be sworn to and signed before any officer authorized to administer an oath, with the same force and effect as if signed and sworn to before the Court.

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CHRISTOPHER EDDY, called as a witness, having been duly sworn by a Notary Public, was examined and testified as follows:

EXAMINATION BY
MR. EVERETT:

Q. Good afternoon, Mr. Eddy. My name is Clay Everett, I am representing Pfizer, Inc. in the average wholesale price litigation.

Would you please state your name and current title for the record.

A. My name is Christopher Eddy, regional manager for provider relations and contracting for the upstate and mid-Hudson region.

MR. BENZA: Before we go any further, I just want to designate at this point the testimony Mr. Eddy gives as highly confidential as permitted by the court's protective order.

MR. EVERETT: Okay.

Q. Mr. Eddy, have you been deposed before?

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A. Yes, I have.

Q. When?

A. Approximately two weeks ago.

Q. In what context?

A. Regarding the TAP litigation.

Q. What in general was the substance of your testimony in the deposition two weeks ago?

MR. BENZA: Objection.

The grounds for the objection is the testimony in the TAP litigation was deemed, it was stipulated as confidential by the parties, by both the plaintiffs and the defendants.

MR. EVERETT: Okay. And I don't want to get into issues of confidentiality or protective order issues with the TAP litigation. Obviously, Mr. Eddy will testify today as to his knowledge with regard to the issues in this litigation.

MR. BENZA: Correct.

Q. But we may certainly deal with some issues that were dealt with in the previous litigation.

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Let me ask you this: What did you do to prepare for your deposition today?

A. I have mainly seen the subpoena and the complaint and I have spoken with my counsel.

Q. When did you speak to your counsel about this deposition?

A. Three, four days ago we talked on it.

Q. For how long did you talk?

A. Approximately an hour.

Q. What did you do to prepare for your deposition in the TAP litigation?

A. Again, I looked at the complaint and subpoena and I spoke with counsel.

Q. Did you speak with the same counsel?

A. I also spoke with another lawyer that was representing us.

Q. Have you spoken to plaintiffs' counsel in the average wholesale price litigation?

A. Plaintiffs in what term, can I ask?

Q. That's a fair question.

In the litigation there are plaintiffs

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who are pursuing claims for damages against defendants and the defendants in this case are pharmaceutical manufacturers.

The plaintiffs in the average wholesale price litigation are for the most part health and welfare benefit funds and public interest groups and they are represented by a variety of lawyers.

A. As far as I know, I haven't spoken to any counsel representing those parties.

Q. Other than your counsel, have you spoken to anyone to prepare yourself for this deposition?

A. No, I have not.

Q. As you have been deposed before, we probably don't need to go through all of the issues associated with the depositions or the ground rules, but I will just run through them quickly just to be clear.

You understand you are under oath today?

A. Yes, I do.

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Q. You understand everything you say, it's just like as if you were in a courtroom, and everything you say must be true and is subject to potential prosecution for perjury.
Because there is a court reporter present today it is important that you answer all my questions orally, the reporter cannot take down nods of the head or shakes of the head.
A. I understand.
Q. It is important you wait until I finish my question before you answer.
Will you do that?
A. Yes.
Q. And I will wait until you finish your answer before I ask another question.
A. Thank you.
Q. Let me know if you need to take a break at any time in the deposition. As long as there is not a question pending, I am happy to do that.
A. Sure.

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Q. And also let me know if you don't understand the question that I ask.
A. Okay.
Q. Do you understand you are here today to testify on behalf of Empire Blue Cross Blue Shield?
A. Yes, I do.
Q. When I ask you questions and use the term "you" I will be referring to Empire Blue Cross Blue Shield unless I indicate otherwise, all right?
A. Yes.
Q. Other than the deposition you gave in the TAP litigation a couple of weeks ago, have you been deposed at any other time?
A. No, I have not.
Q. Mr. Eddy, would you run through your education for me after high school.
A. I have a two-year degree from State University of New York at Cobleskill, that was obtained in 1987 in computer science.
After that, while I was working, I went back to school part time and I received a four-year degree in computer information systems from Empire State College.
Q. After you completed your last degree, did you go to work?
A. I was actually working during that time frame.
Q. Where were you working during that time frame?
A. Empire Blue Cross.
Q. What was your position at that time?
A. It would have been in provider relations, I would have been a provider relations coordinator.
Q. What were your duties as a provider relations coordinator?
A. I was responsible to identify providers for recruitment for our provider network. Once those providers were recruited, I worked with their staffs to educate them on our products and the different guidelines they needed to follow, I worked with them if they had

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any problem resolution.
Q. What do you mean by problem resolution?
A. If they questioned the processing of a claim, the claim denied, they didn't know the reason why, I would assist them with that.
Q. How long did you hold the position as provider relations coordinator?
A. Approximately three years.
Q. That would take us to what date, approximately?
A. Into '96, sometime in 1996.
Q. What position did you assume at that time?
A. At that time I was promoted to a senior provider relations coordinator.
Q. How did your duties vary?
A. I maintained the same responsibilities as the coordinator, I assumed responsibilities to lead seminars for providers in different areas. In addition to that, I assisted my supervisor at that time and attended meetings on

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her behalf if she wasn't able to.
Q. What sort of meetings would you attend on behalf of your supervisor?
A. Going way back, so I would have to say at the time, most likely it was credentialing, attendance at credentialing meetings, and other than that -- I definitely remember credentialing.
Q. What do you mean by providers in the context of your work as provider relations coordinator?
A. Providers are the physicians that make up our network or allied providers as you would call them, that would be your podiatrists, your physical therapists some medical providers is mainly what we serviced in our department.
Q. During this time period, did you have any duties relating to pharmaceutical products?
A. No, I did not.
Q. How long did you hold the position of senior provider relations coordinator?
A. Approximately seven years.
Q. Until approximately 2003?

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A. Actually until January of this year, 2004.
Q. What position did you assume at that time?
A. At that time I took the position as regional manager for provider relations upstate.
Q. How did your duties change?
A. The biggest change I had at that point was I became responsible for a staff of seven employees and having to work with them and help them out in their areas.
Q. Other than the duties that you had performed as provider relations coordinator, what other duties are performed by the staff of seven employees over whom you now have supervisory responsibility?
A. I have six coordinators. Of the six, one of them is a senior provider relations coordinator. They are all responsible for territory in the upstate mid-Hudson region and I have one internal representative which is a provider relations associate.

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Q. How are the duties of the provider relations associate different than the provider relations coordinators?
A. The associate is actually an internal position, they assist the staff if they have questions or they are working with doctors. The coordinators travel, on a weekly basis they are outside of the office two or three days a week, so the internal person helps them get their work done. In essence, that's what the position does.
Q. Do the six provider relations coordinators have duties different than the duties you had as provider relations coordinator?
A. It is pretty much identical. I mean, as time has changed, we have picked up a little different responsibilities now.
Q. Are you involved at all in contracting with providers?
A. In what terms are you looking at contracting?

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Q. Any terms at all.
A. Recruiting, that type of contracting, yes, we go out and recruit with the physicians and we would supply them with an agreement if they would like to participate.
Q. What do you do to recruit physicians?
A. Mostly right now the recruitment is based on network need, if we do not have a provider in a particular specialty, or we are mainly getting providers that call us up asking to participate.
Q. How do you determine if you have a network need for a particular type of provider?
A. What we look at to determine the network need is, say you have a particular county and there are no providers participating in a certain specialty and New York State indicates that there are providers available, we will try to identify those providers and see if they are interested in participating with our products.
Q. What do you do to interest providers

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in your products?
A. We mainly have a little information that we go out, just telling them the different products that we offer and what would be their responsibilities in our network if they joined those programs and we kind of go out and talk with them about that, listen to what their questions are.
Q. If physicians are interested in joining your network, how do you get them to join?
A. If they are interested we give them an application -- I should say, excuse me, it's an agreement, and a cover sheet and the providers would complete those two documents and return them back to their coordinator.
Q. Do you negotiate with providers about any terms of the agreement that will govern their relationship to Empire?
A. The physician managed care and the PPO agreements are non-negotiable, the wording in those contracts.

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Q. So Empire uses standard contracts for all of its network providers?
A. Yes.
Q. Are the fees for provider network set out in those contracts?
A. Without actually looking at the contract right now, I do not -- they are not mentioned directly, it just references Empire's managed care fee schedule.
Q. Do you discuss the fees paid to providers with providers when recruiting them to the Empire network?
A. If the provider asks for that information.
Q. In your experience, do providers generally ask for information about the fees that will be paid by Empire?
A. Yes.
Q. Do providers ever ask about fees that will be paid by Empire for drugs dispensed in their offices?
A. We do on occasion get questions.

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Q. Other than those discussions, do you have any responsibilities other than those --
MR. EVERETT: Strike that.
Q. Other than those discussions with providers in the context of recruiting them to the Empire network, do you have any responsibilities related to pharmaceutical products?
A. No, I do not.
Q. Let's talk about Empire, the corporate entity, a little bit.
Empire is a managed care organization; is that correct?
MR. BENZA: Objection to the extent that calls for a legal conclusion.
A. It has a varied, a variable amount of products, some of which are managed care programs.
Q. What types of products does Empire offer?
A. We offer an HMO product or an HMO network, I should say, with products available

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within that network. One of such products is what we call our direct HMO.
Would you like specifics on that or just the names?
Q. Let's run through the names first.
A. Plain HMO, Direct Pay HMO, Child Health Plus and Healthy New York.
Q. Does Empire offer any non-HMO products?
A. I just wanted to add one more to that. There is a senior plan. I'm sorry, I forgot that one.
Go ahead.
Q. Does Empire offer any non-HMO products?
A. Yes, we do.
Q. What are those products?
A. Preferred provider organization, which is a PPO, exclusive provider organization, which is an EPO.
Q. How do the HMO products differ from the PPO products?

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A. Usually the HMO network is a smaller subset of physicians that are available for the members to see. Depending on which product the member has, they have responsibility to get a referral from their primary care physician for any services through a specialist. Some products do not have referral, do not require referrals.

Q. How does the exclusive provider organization differ from the HMO product?

A. The exclusive provider organization, the member can see any provider in our PPO network, as we call it, any participating provider for coverage services without a referral, they can self-refer. If they decide to see a doctor or provider that does not participate, the member is going to be responsible for the charges.

Q. Do all of the products offered by Empire Blue Cross and Blue Shield provide coverage for pharmaceutical companies?

A. I can't answer that because I don't work on the pharmaceutical side of it, so that would be specific to those groups when they purchase from us.

Q. What do you mean by groups when they purchase from us?

A. Well, most of these products, when you look at them, are usually bought by employer practices, employer groups, and those groups can choose their benefits, those groups decide whether they want pharmacy benefits or not and we have no part of that decision, it's the employer groups.

Q. For those products that do offer pharmacy benefits, are groups that purchase those products able to negotiate for the different copays and coinsurance to be paid by their beneficiaries for those products?

A. I don't work with the groups in selling it, so I couldn't tell you what the groups choose, how they choose it, but the identification card that the member has indicates their copayment amounts if they have a benefit available.

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Q. Does Empire have standard copays and coinsurance for pharmaceutical products?

A. I couldn't answer that for you.

Q. Geographically, where does Empire operate?

A. We have 28 counties in New York that we operate in as well as operating as Well Choice in New Jersey.

Q. Does Well Choice offer different products than Empire New York?

A. They offer similar products. There may be a few products that are specific to New York State that they don't offer down there.

Q. What are Empire's competitors?

A. It probably will depend on which area you are looking at. In my upstate region my competitors are MVP, which is Mohawk Valley Health Plan, as well as Capital District Physicians Health Plan.

As you come down here to New York City that changes differently because there are different groups down here. You probably have Oxford, Aetna U.S. Healthcare, GHI. Those are just some of the competitors.

Q. How do you know those companies are competitors of Empire?

A. They offer products in the same market that we offer products in and via commercials on TV or newspaper articles you see their names.

Q. What are the facets of competition between Empire and those competitors?

A. They are probably -- all of the insurance companies are looking for consumers for their products.

Q. What does Empire do to attract consumers for its products?

A. The best way probably would be able to have competitive prices with premiums.

Q. To offer competitive prices for premiums, is it important for Empire to keep its costs of doing business low?

A. Based on my knowledge, I would say yes, but I don't know for the company as a

whole.
Q. Is it important to Empire's competition with its competitors to have a large network of providers available to beneficiaries of Empire?
A. The size of the network isn't always the best to drive that.
Q. Do you believe competition is mainly in terms of the price?
A. It's probably the main part of it.
Q. How is Empire organized internally? Are there different divisions of Empire?
A. Yes, there are.
Q. What division do you work for?
A. I'm in operations.
Q. Other than operations, what other divisions or groups are there?
A. It would be easier if I had an organization chart to show you all that. I am trying to think offhand.
Just briefly, there's probably a finance and sales or marketing, I should say.

Q. How is the operations group organized?
A. Well, I can only speak for, like, my area of the operations department that I deal with. There is a division that deals specifically with hospitals and then there's a division of us that deals with the provider relations. There could be another few areas pulled into there that I am not involved with, but those are the main two I am dealing with under operations.
Q. In what division is the pharmacy department?
A. Honestly, I don't know that.
Q. Do you have any interaction with the people who work in the pharmacy department?
A. Occasionally I will be at a meeting where they are at for some reason, but that's usually the only points that I have involvement with them.
Q. Mr. Eddy, I am going to hand you what's been marked as Eddy Deposition Exhibit 1.
(Exhibit Eddy 001, two-page

list of deposition subjects, marked for identification, as of this date.)
Q. This is a list of deposition subjects. Just so you know, it's a two-sided document and all of the documents I will give you today are two-sided.
Take a minute and take a look at that.
Mr. Eddy, have you seen Deposition Exhibit 1 before?
A. Yes, I have.
Q. Do you understand that you are here today to testify regarding some of the subjects that are identified in Deposition Exhibit 1?
A. Yes.
Q. Which subjects are you prepared to testify about today?
A. I can speak specifically regarding questions on the provider side, medical providers.
Q. Are you the person at Empire that's most knowledgeable about the subjects that are identified in Deposition Exhibit 1 on the

provider side of the business?
MR. BENZA: I am going to let him answer but I do want to object to that question.
There was discussion, obviously, between counsel and Mr. Eddy was proffered as the witness on these particular topics more than anyone at Empire, in our opinion, would be able to talk on these topics.
I will let him answer the question in his opinion, but as I say, that's been a matter of discussion by counsel, both sides, and he has been agreed to as the witness today for this topic.
MR. EVERETT: Just so that you understand, we have had some discussions with the counsel that represents Empire, the outside counsel that represents Empire, but we were just given a list of names and there wasn't a specific discussion about particular individuals.
I understand you have proffered

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Mr. Eddy as a witness to testify about provider relations and I am just trying to explore the extent of his knowledge.

MR. BENZA: That's fine.

A. Based on my 13 years of experience in provider relations, I was asked to do this because of the knowledge that I have.

Q. Mr. Eddy, have you heard of the term "AWP" in reference to pharmaceutical products before?

A. Yes, I have.

Q. What do you understand that term to mean?

A. It's actually the average wholesale price.

Q. To what do you understand average wholesale price to refer?

A. The cost of the drug that's determined by the manufacturer.

Q. What is the basis for your understanding of the term "AWP"?

A. My experience working with provider

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offices.

Q. In what context has your experience in dealing with providers' offices given you some understanding of the meaning of the term "AWP"?

A. I would be asked questions regarding AWP when I was a provider relations coordinator, so during the context of my position I had to gain some knowledge into what the AWP was so I could answer questions to the physician offices.

Q. How did you gain knowledge about AWP?

A. Mainly at that time back then talking to my peers in my department, trying to -- I think at the time back then we had a copy of the drug topics red book in the office and I was able to look up and find information regarding that and then knowledge from talking to provider offices and the physicians in the office.

Q. Did you talk to any of your peers in the pharmacy department of Empire about the meaning of AWP?

A. No, I did not.

Q. You do know who is in the pharmacy

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department at Empire, do you not?

A. I will say more so now than back then, yes.

Q. If you wanted to contact someone in the pharmacy department of Empire, you could do so, could you not?

A. Yes, I could, yes.

Q. In response to a previous question you indicated that you understood AWP to refer to the cost of a drug that is determined by manufacturer.

The cost to whom?

A. That they would supply it to the entities purchasing it.

Q. What entities do you understand purchase drugs from manufacturers?

A. Physicians offices can purchase drugs directly or they go through another provider to purchase those drugs.

Q. Other than physicians' offices, what other entities purchase drugs from manufacturers?

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A. Mainly I deal with physicians' offices because that's where my questions come from. I don't know of any other option where they purchase those from.

Q. To be clear, did you understand the term "average wholesale price" to refer only to the cost of drugs purchased by physicians' offices?

A. Yes.

Q. To be clear, again, you did not understand the term "AWP" to refer to the cost of drugs purchased by hospitals?

A. I couldn't answer that because I don't have experience working on the hospital side, so I don't know there.

Q. The same question for pharmacies.

MR. BENZA: Could you actually repeat the question?

Q. Did you understand the term "AWP" to refer to the cost that pharmacies paid to acquire drugs?

A. I don't have any experience with the

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pharmacy side, so again, I wouldn't have any information there regarding the pharmacies' cost.

Q. Did you believe that all providers purchased pharmaceutical products at the same cost?

A. I had no reason not to believe that. I have always thought they always paid the same price.

Q. To clarify, you believed that all providers paid exactly the same price for pharmaceutical products?

A. Right. Based on the territories that I handled, the questions that I always saw was always the same. I don't know if in other geographical regions if that price would change, but I assumed it was the same.

Q. Did you understand that the published AWP to include discounts provided to providers?

A. I did not know of any discounts.

MR. HOFFMAN: Objection.

Q. You can answer the question.

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A. Sorry.

Can you repeat that for me? I am sorry, I lost my train of thought.

Q. Did you understand the published AWPs to reflect discounts received by providers purchasing pharmaceutical products from manufacturers?

MR. HOFFMAN: Same objection.

A. I did not know of any discounts, I had not heard of any discounts.

Q. Do you know that providers receive educational grants in some cases from pharmaceutical manufacturers?

MR. BENZA: Objection.

A. I don't have any knowledge of that.

Q. Do you know if providers receive free samples from pharmaceutical manufacturers?

A. Based on my knowledge, being in the field, I have seen drug vendors bring in drugs to the doctor's office and leave them with them. I don't know if the office paid for them, if they were free, but I have seen them bring drugs

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into the office.

Q. Has your understanding of the term "AWP" changed at all over time?

A. No.

Q. It is the same today as it's always been?

A. Yes. It might have been a little more comfortable now with more experience, but it's been the same.

Q. Did your understanding of the term "AWP" affect in any way the activities that you performed on behalf of Empire?

A. No.

MR. HOFFMAN: Objection, vague.

Q. Mr. Eddy, in your position as regional manager of provider relations, if I have the title right -- Mr. Eddy, in your position as regional manager for provider relations, is it important for you to keep up to date on drug pricing issues?

A. No.

Q. Because your job has nothing to do

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with pharmaceutical products; is that correct?

MR. BENZA: Objection to the characterization.

A. We deal with questions, but other than pharmaceutical benefits, you are right, we do not specifically deal with the pharmacy benefit in our position.

Q. Do you play any role in determining the fee schedules for providers in the Empire network?

A. The mechanism that we use to determine fee schedules is confidential with us. We do -- our department will look at CPT codes, which are the current procedural terminology codes, and we do monitor those codes and a fee schedule is based off of Medicare.

Q. What do you do to monitor CPT codes?

A. In the past, when they created our managed care products, they used a percentage of Medicare and they do -- I can't recall when the last one was done, but they do an analysis occasionally to see where our fees compare in

the current fees to make sure we are still competitive.
Q. How do you determine if you are still competitive?
A. Usually that will be determined because we will get a lot of providers calling you because they are not happy with our fee schedule. That's a major indicator.
Q. What do you mean, they are not happy with your fee schedule?
A. They just contact their coordinators and tell them that what we are possibly paying for an office visit, what we are paying is lower than our competitors and they are not happy that our fees are so low or at that point they would like to them look into that or something.
Q. Does Empire ever adjust its fees in response to that type of competition?
A. Overall there's been one fee schedule normalization over the past, I don't know the exact time frame, but within the last, I would say within three years there was one, and that's

the last time I remember an update being made to the fee schedule.
Q. How often is the fee schedule updated?
A. Not very often.
Q. Does Empire have a single fee schedule for all of its products?
A. There are separate fee schedules.
Q. Separate fee schedules for what?
A. Based on regions. You are based on -- there is Manhattan, outer boroughs, upstate, mid-Hudson, because Medicare has different regions.
Q. Is there a constant relationship between the Medicare fee schedule and the Empire fee schedules?
MR. BENZA: Objection to the term "constant."
A. I have not been involved in all the normalizations up through, so I couldn't tell you specifically if there has been a constant the whole way through. This fee schedule was created on the basis of one particular year of

Medicare.
Q. Which particular year of Medicare?
A. 1994.
Q. Are you familiar with the fee schedule for the upper Hudson region of which you are regional manager of provider relations?
A. Yes.
Q. What is the relationship between the prices in the fee schedule, the Empire fee schedule for the upper Hudson region and the Medicare fee schedule?
A. An actual percentage I couldn't give you because over the years Medicare has raised certain codes and decreased certain codes, so when you look at the fee schedule some areas will differ, but the percentage is still there from the basis when you look at the original year when it was created.
Q. What is the percentage difference from the basis year it was originally created?
A. The actual at the time was 125 percent is the percent of 1994 Medicare, RBRVS.

Q. How did Empire decide to set its fee schedule at 125 percent originally of the 1994 Medicare RBRVS fee schedule?
A. I honestly -- I can't tell you, I don't know, I wasn't involved in the decision-making at that time of the fee schedule, so I don't know the decisions that were made.
Q. Do you know how often the Empire fee schedule has changed since it was originally put in place?
A. At this time there hasn't been a complete fee schedule change. There has been at least one fee schedule modification in the time frame, and I don't recall the actual time frame for that or the change in what it was.
Q. How was the fee schedule modified?
A. I remember them looking at codes and updating codes because Medicare had increased the codes and from volume of calls from providers in certain areas, and the company went back and looked at those. I don't specifically

remember which codes they were that were the basis of the modification back then.
Q. Individual codes were modified in the course of this modification?
A. Yes.
Q. Do the Empire fee schedules include fees that will be paid for physician-administered drugs?
A. The fee schedules would only cover those CPT codes, so for a CPT code, there is an administration code. Those administration codes would be covered under the Medicare fee schedule, so our fee schedule would be based on what Medicare was.
MR. BENZA: Do you need to stretch your legs?
THE WITNESS: I will be okay, but in a minute I would like to get up and stretch, that would be good.
Q. We will go just a couple more minutes and then take a break.
Are the prices for physician-administered

drugs as opposed to the administration of those drugs included in the fee schedule?
A. Can you be a little bit more specific on that, what you are --
Q. Are you familiar with J codes?
A. Yes.
Q. Does Empire reimburse physicians for physician-administered drugs based on J codes?
A. The J codes are published off the NDC values and they appear in the drug topics red book.
Our reimbursement for drugs is based on the AWP, average wholesale price, it is not based on the Medicare fee schedule.
There are certain codes I will say that Medicare puts out for immunizations that our fee schedule is based on Medicare's pricing for the immunizations and they have a CPT code, the price of that, and those J codes that don't have a CPT like you are talking about were based off of AWP.
Q. Where would those AWP-based prices for

J code drugs that don't have a corresponding CPT code be found?
A. The pricing for those is just -- we utilize the drug topics red book and the price will be in that book right there for the corresponding drug.
Q. Is there a separate fee schedule for those physician-administered drugs?
A. No. It's based specifically off of the AWP.
Q. Do any of the contracts that Empire has with providers identify the basis for reimbursement for physician-administered drugs where there is no CPT code?
A. Can you give me a little bit more clarification?
Q. Empire reimburses some physicians for physician-administered drugs based on AWP; is that correct?
A. Yes.
Q. Is there any contractual obligation that Empire has with its providers to base its

reimbursement on that AWP basis?
A. The establishment of the fees is something driven by the company, the company decides the net reimbursement, and as long as I recall in the department it's always been based on AWP.
Q. Let me just clarify a little bit more.
Empire produces and publishes a fee schedule that it provides its providers; is that correct?
MR. BENZA: Objection to publishes.
A. We did, at one point we had a published fee schedule of selected codes. As far as I know, that hasn't been maintained at this time, but if a provider asks for reimbursement, the coordinators would respond to the provider and give them the pricing for the CPT codes.
Q. How do providers know how much they will be reimbursed by the provider for physician-administered drugs?
A. In most cases, the provider will

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usually ask their coordinator or call the coordinator and ask them what our reimbursement is and that would be advised to the provider.

Q. To your knowledge, are those reimbursement terms set out in any contracts between Empire and providers?

A. To my knowledge, the fees, the contracts in the agreements references managed care fee schedule and I do not recall seeing anything specific in that wording to AWP.

Q. And just to be clear, the managed care fee schedule does not include schedules for physician-administered drugs; is that correct?

A. Yes.

MR. EVERETT: Let's take a short break.

We will break and reconvene in 10 minutes.

(Recess taken.)

BY MR. EVERETT:

Q. Mr. Eddy, have you heard of a term WAC in reference to pharmaceutical products?

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A. In just looking through the complaint.

Q. Other than in the complaint?

A. No, I have not.

Q. Mr. Eddy, are you familiar with a term "MAC" in the context of pharmaceutical products?

A. Again, I just saw it, again, in the context of the complaint and I don't have any knowledge other than that.

Q. To your knowledge, does Empire reimburse for any pharmaceutical products based on MAC?

A. I do not know.

Q. At what rate does Empire reimburse providers for physician-administered drugs?

MR. BENZA: Objection to rate.

A. Are you specifically referring to the J codes, as you referenced earlier?

Q. Let's talk about the J codes first.

What is the basis for reimbursement of J code physician-administered drugs by Empire?

A. Depending on the product, the reimbursement is set and the basis is the

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average wholesale price.

Q. Does the reimbursement differ by product?

A. Managed care products in the HMO network are being reimbursed at AWP, straight AWP; the products in the PPO network are being reimbursed at AWP plus 30 percent.

Q. Are those the rates used for all physician-administered drugs that are dispensed by physicians to beneficiaries of Empire utilizing the HMO products and PPO products?

MR. HOFFMAN: Objection, vague as to time.

A. Can you be a little bit more specific for me on the question?

Q. Do those rates apply to all physician-administered drugs?

MR. HOFFMAN: Same objection.

A. Yes, they do.

Q. Have those rates changed over time?

A. At one point, and it was probably in the early nineties, I don't know the actual

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date, everything was reimbursed at AWP plus 30 percent.

Q. Why was the reimbursement changed for the HMO products?

A. I was not involved with that change, so I don't know the reasoning for the change.

Q. How does Empire determine the amount that it will pay for physician-administered drugs?

A. Empire, since we started, as far as I recall, with the company, has always been the AWP, that's always been the basis for the drugs.

As for the percentages that are established, that would have been determined most likely by recommendations of management at that time.

Q. How did management determine the percentage of AWP paid for physician-administered drugs?

A. Since I wasn't involved when they made that change, I couldn't tell you the specifics that they looked at to make the determination of

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that.
Q. Who would know the answer to that question?
A. I actually don't -- my boss who was involved with that at the time has passed away, so other than that I don't know who was involved in making that decision, so I don't think I could tell you another person.
Q. What position did your boss hold?
A. She was the director of provider relations in the upstate mid-Hudson region.
Q. Has Empire considered changing the percentage of AWP that it pays for physician-administered drugs?
MR. BENZA: Objection as to time frame.
Can you put a time frame on that?
Q. At any time.
A. It has always been based on AWP. In 2003 we went with a program through Specialty Rx Empire started.
Q. Other than the program with Specialty

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Rx, to your knowledge, has Empire ever considered changing the percentage of AWP that it will pay physician-administered drugs?
A. Other than that, I have no knowledge of any.
Q. Have you had any discussions with management about the percentage of AWP that's paid for physician-administered drugs by Empire?
A. No, I have not.
Q. Do you know what factors were considered by management in setting their recommendation to pay for -- pay AWP plus or minus no percentage for HMO products?
A. I do not.
Q. Do you know why Empire uses AWP as a basis for its reimbursement of physician-administered drugs?
A. It's actually published in sources that it's easy for the providers to see what the pricing is, so the published drug topics red book is the one that we use, it is an easy source for providers to obtain pricing.

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Q. For the providers to obtain pricing?
A. Yes. The provider offices can purchase the drug topics book and also see what the cost of the drugs are. Anybody can purchase the book.
Q. Does Empire ever reimburse providers at their billed charges for physician-administered drugs?
A. We would only reimburse at the AWP. I mean, the contract has wording in it for reimbursement of the fee schedule or lesser of, if they ever billed lesser than the AWP. I have never seen that happen.
Q. Are you familiar with the Empire claims database system?
A. I have a little bit of experience with it, not a lot.
Q. Is there any way to differentiate, when looking at a claim in the Empire claims database, between claims that were paid based on a percentage of AWP and claims that were paid based on billed charges?

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A. I have actually never looked specifically at that, so to tell you, I don't know, I never looked specifically.
Q. Have you done anything in the past to determine whether Empire is making payments for physician-administered drugs based on billed charges?
A. I have actually no reason to believe that was the case, so I have never done any research.
Q. Are you familiar with the term "usual and customary"?
A. Yes.
Q. What do you understand that term to mean in the context of pharmaceutical products?
A. As it refers to pharmaceutical products, I couldn't answer in that context. I know from the medical side what it would be.
Q. What do you understand that to be in the medical context?
A. Usually what will happen, if a provider does not participate, they set up,

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there's usual and customary charges that are set up and that's what the providers are reimbursed at, the ratio for reimbursement, and they set it that way because if the providers, first of all, don't participate with the program, the member has got to be responsible for charges, so they look at the claims that way, the usual and customary. It's usually a higher reimbursement for the physician.

Q. How is usual and customary determined?

A. From my experience with that, it is based on billing of claims coming in of providers and the charges that the system sets up, it tracks it and the fees, to my knowledge, that's how it is set up.

Q. To your knowledge, does Empire reimburse physicians ever for physician-administered drugs based on usual and customary charges?

A. I have actually never seen it based on that, so I have no knowledge of that.

Q. Does Empire reimburse physicians

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separately for services provided in the administration of physician-administered drugs?

A. The physician billing the administration code could be reimbursed separately when billed with the drug.

Q. Are you aware of any complaints by providers that the amount paid by Empire for the administration of physician-administered drugs is insufficient to cover the costs associated with administering physician-administered drugs?

A. I -- in the time frame I have been doing this, I do not recall any providers questioning the administration charge that we pay.

Q. Are you aware generally of any such complaints about the amount paid for the administration of physician-administered drugs?

A. Usually, if a provider has a concern, they address it to the coordinators and my staff will bring that to my attention, let me know, and I don't remember anybody specifically saying that.

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Q. What is the Independent Practice Association?

A. They are also known as an IPA. They are very rare upstate, in my territory, so I don't have a lot of experience in dealing with them or even working with an IPA, usually.

Q. Do you understand what an IPA is?

A. I have heard the terminology before. Since I really haven't dealt with them, I really don't have a very strong understanding of that.

Q. In what context have you heard the terminology?

A. Usually how a group forms or they set themselves up as an IPA, a practice association, and just pretty much how the group is set up is my knowledge of it.

Q. How is an IPA set up?

A. Just from what I have seen, it's usually a group of providers that form a practice together and that's my understanding of an IPA.

Q. What functions does an IPA serve?

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A. Since I haven't had much experience with them, it is hard for me to tell you what functions they would serve. I really have not had any dealings with them, so I don't get involved in that piece of it.

Q. Do you have a general understanding of that?

A. Well, they probably would hire an administrator to manage their practice and they would probably try to work in the best interests of their practice; I would assume that's what they would be looking to do.

Q. Does an IPA pool the resources of the physicians that belong to it?

A. It probably would be on their best behalf to do that.

Q. Why would physicians want to pool their resources?

MR. BENZA: Objection.

A. I would be guessing, because I am not a physician's office, but to see that, they probably -- I would assume they would operate

more smoothly, the company would, the group, the practice would, to pool the resources.
Q. What do you mean, operate more smoothly?
MR. BENZA: Objection.
A. Again, not being in a physician office, it is hard, because I am not seeing it from their eyes how they are doing it. Usually they could utilize the same people to do billing, the same people to do services in the group, instead of having separate billing practices in each one of the doctors' offices.
Q. Does Empire pay any physicians based on a capitated fee schedule?
A. As far as I know, at this time, we do not pay on a capitated fee schedule, everything is on a straight fee schedule.
Q. Has Empire ever paid physicians based on a capitated fee schedule?
A. I don't recall us ever using a capitated period.
Q. I am handing to you know a document

marked Eddy Deposition Exhibit 2. This is a document bearing Bates numbers EMP 5669 through EMP 5682.
Take a minute to look through that.
(Exhibit Eddy 002, documents bearing production Nos. EMP 0005669 through EMP 0005682, marked for identification, as of this date.)
MR. HOFFMAN: Give me a minute, please. I am trying to locate that.
Q. Have you had a chance to look through the document?
A. Yes.
MR. EVERETT: Allan, have you found the document?
MR. HOFFMAN: Not yet. Give me one more minute to see.
Q. Mr. Eddy, what do you understand this document to be?
A. This is the first time I have seen this document. It's actually something specific to downstate which we don't have upstate, so

this is something new. It's an IPA agreement.
Q. Do the terms of agreements by Empire with its providers vary by geographic region?
A. The agreement that a physician signs to participate is the same for all the providers in our service area in New York State. There's a few minor changes in New Jersey because the department down there makes those changes, so every provider would sign the same agreement.
Q. In your region, the upper Hudson region, Empire has no agreements of the type like Eddy Deposition Exhibit 2?
A. Right now upstate I don't know of any IPAs that are contracted upstate as this is downstate, something specific to this market down here.
Q. Turn, if you will, please, to page EMP 5677, page 9 of the document.
Look, if you will, please, at the paragraph 7-B.
Does this contract indicate that physicians who are members of the IPA that is a

party to this agreement will be paid by Empire on a capitated basis?
MR. BENZA: Objection. The document speaks for itself.
Q. You can answer the question.
A. Since I wasn't the author of this, it does mention capitation here, but I don't know the context that they were putting that in when they wrote it, what they were doing with the policy with respect to this specific group.
Q. Does paragraph 7-B indicate that Empire will pay physicians a flat fee?
A. It indicates capitation in that paragraph, it does not indicate a flat fee, but not knowing the specific contracts, I couldn't speak for the specific contract, what the actual that is going on with this group.
Q. You are familiar with the term "capitation," aren't you?
A. Yes.
Q. What do you understand that to be?
A. It is a payment made from the

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insurance company to the group on a per-member per-month basis, the price they are paid on a monthly basis, and that price covers all of the medical care they handle for that patient.

Q. In your understanding in general, the term "capitation," do you believe it covers physician-administered drugs?

A. I honestly do not know if this covers that or not. It doesn't indicate here, so I couldn't tell you. I don't know.

Q. I am not asking about this document in particular.

In general, do you understand capitation contracts for physician services to include physician-administered drugs?

A. I don't know if it is covered or not.

Q. Other than this contract, are you aware of any other capitation agreements between Empire and physicians?

MR. HOFFMAN: Objection, mischaracterizes the document.

A. At this time, I am not aware of any.

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Q. Has Empire ever employed a benefits consultant, to your knowledge?

A. I do not recall or remember anything.

Q. What are benefits consultants?

A. I honestly do not know.

Q. Have you ever heard of the term "benefits consultant"?

A. No.

Q. Does Empire have any contracts with hospitals?

A. There is a department that does contract with hospitals.

Q. Does Empire have any contracts with those hospitals through that department?

A. I know they contract with them, so there must be contracts there. It's not in my area of my department, so I physically have not seen any, but I know they contract with them.

Q. On what basis does Empire reimburse hospitals for drugs administered in the hospital?

MR. HOFFMAN: Objection, lacks foundation.

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MR. EVERETT: Just for the folks on the phone, I would appreciate it if you allow me to finish the question, please.

Q. Go ahead.

A. I am not involved with the hospitals, so I couldn't tell you, I don't know what their basis is for their contracting in their setting.

Q. Who would know that?

A. That would be the hospital contracting department.

Q. Who within the hospital contracting department?

A. The person that handles it upstate, the director upstate is Barry Brandau.

Q. Is the hospital contracting department divided geographically by region?

A. Yes, it is.

Q. Is there any centralized hospital contracting department?

A. Each region has their own person in charge of the region and they report up to,

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like, their supervisor or vice president that's in charge of the division.

Q. Is there a supervisor or vice president to whom you report?

A. I report to a director of provider relations.

Q. Does the director of provider relations have responsibility for provider relations in all of the regions in which --

A. Yes.

Q. -- Empire -- I would appreciate it if you would wait until I finish the question.

Does the director of provider relations have responsibility for provider relations in all of the regions in which Empire does business?

A. Yes, he does.

Q. Who is the director of provider relations?

A. Paul Portsmore.

Q. Do you know how long Mr. Portsmore has worked for Empire?

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A. I do not know the length of time he has been with the company.
Q. How long has Mr. Portsmore held the position of director of provider relations?
A. Between one and two years, a short time.
Q. How do Mr. Portsmore's responsibilities differ from your responsibilities?
A. He would be responsible for managers in all three of our regions and he would report directly to the vice president of our division.
Q. Who is the vice president of your division?
A. Dan McCarthy.
Q. What is the division named?
A. Managed care operations. It might be changed recently, but that's what I remember.
Q. Do you have meetings with the other regional directors of provider relations?
A. We do on occasion, yes.
Q. How often?

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A. The last one is probably about a month ago.
Q. Are they held periodically, those meetings?
A. They used to be and then it's changed a little bit recently.
Q. How often did you used to have meetings?
A. We used to have them on a monthly basis.
Q. When did it change?
A. Probably around May.
Q. Now how often are these meetings held?
A. Actually, the one we held the other day is probably the first one we've had since May.
Q. What explains the change?
A. There's just been some changes going on with the division with changes in where people report, just day-to-day activity they have been changing.
Q. What changes?

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A. They are looking to take the contracting out of provider relations, we are going to deal specifically with provider relations, and then there will be a part of the people that will deal specifically with the contracting piece and that's what's in process right now.
Q. What's the contracting piece?
A. Mainly the contracting piece deals specifically with the hospitals and sometimes they handle large groups through the contracting piece. They are currently working on that process right now.
Q. Does the contracting piece involve individual negotiations about contracts?
A. As for contracts, we don't negotiate individual contracts, it's the standard contract that everybody utilizes, so contracting would not deal with the agreements, the negotiation of the contract.
Q. What does it deal with exactly?
A. Contracting deals with the larger

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groups that we have or the facility practices in some of our areas where we negotiate with those groups, reimbursement specifically.
Q. And it deals with them in what way?
A. They would work with those groups to set up reimbursement based on CPT codes at a different fee schedule than our providers.
Q. Are separate fee schedules negotiated with particular hospitals?
MR. BENZA: Objection.
Hospitals?
A. Hospitals aren't in my area of knowledge, so as for hospitals, I couldn't speak on how they are handled.
Q. You just mentioned that there were negotiations about how to set up reimbursement.
To what were you referring?
A. When I stated that a minute ago, I stated with large faculty practices, which are the physician groups or large provider practices. It is specific to physicians, it has nothing to do with hospitals.

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Q. Are separate fee schedules associated with large faculty practices?
A. There have been some occasions when negotiations have been completed with groups.
Q. Have you been involved in any of those negotiations?
A. I have been involved in a few of them upstate.
Q. When was the first such negotiation that you were involved with?
A. I don't recall an actual date. Probably within the last seven years is the first one.
Q. With what large faculty practice did you negotiate a separate reimbursement schedule?
A. We actually did it with a provider's office in a particular county where we had a network need and there were selected procedure codes only, CPT codes.
Q. Why did you negotiate separately with that provider's office?
A. There was a network need that if we

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lost the provider's office we wouldn't have a provider available to treat our patients.
Q. What CPT codes were changed?
A. Specifically, I don't remember the codes. Most -- the providers most likely identified E&M codes, which are your office visit codes. Those are usually the high volume codes that they bill.
Q. What type of provider was it?
A. It was a multispecialty group where they had multispecialties.
Q. What were the specialties?
A. They had primary care specialties as well as specialties such as gastro.
Q. Did that negotiation involve any oncologists?
A. I do not recall any oncologists in that group.
Q. Did it involve any rheumatologists?
A. No.
Q. Was there any discussion about physician-administered drugs?

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A. If a group ever asked regarding physician-administered drugs, as a company we do not negotiate those prices for the physician-administered drugs.
Q. Does Empire negotiate prices for other codes?
A. It would be specific to the codes listed in the current procedural terminology book, the CPT codes would be the only ones that we would negotiate.
Q. Empire does on occasion, they negotiate about CPT codes?
A. The CPT codes are in the current procedural code manual, so yes, those codes upon occasion would be negotiated.
Q. Why does Empire negotiate about those codes and not about physician-administered drugs?
A. In my experience in dealing with the providers' offices I have never had a provider ever question the reimbursement of a drug by Empire, so based on that information, we've

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never had the need and we've always determined that since we haven't had the need, that that is something that we never negotiated on.
Q. I thought I understood you previously to say that Empire had a policy of not negotiating about physician-administered drug reimbursement.
Is that correct?
A. That is correct.
What I said a minute ago, the reason we've never negotiated and we made it the policy, as I stated earlier, is we've never had any complaints back, and based on that, we made the policy and we said we would never negotiate the AWP prices based on that. I apologize.
Q. In negotiating fee schedules with particular providers, is Empire interested in what its bottom line cost is likely to be?
MR. BENZA: Objection.
A. Usually when we negotiate with the providers' offices, we only know what the negotiation, how it impacts the group.

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As for the bottom line of the company, we don't compare it to what it does overall to the company, just the group.
Q. How do you analyze the impact of the fee schedule changes on the group?
A. We look at the volume of services they billed in a certain time frame, according to the requests, and kind of look to see what they are looking for and try to come up with a mutual arrangement between both parties.
Q. How does the volume of services play into your analysis?
A. It gives me an idea to see, first of all, what we are going to be reimbursed, but it also gives me an idea of what the groups being reimbursed which, we know they have already done their research on that, too, what they are looking for.
Q. How do you decide whether to accept an offer of a different fee schedule from a provider?
MR. BENZA: Objection.

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A. Specifically, when a doctor puts something to us in writing, we review the request and we look if there is a network need for the provider or that provider left our network, would we have providers that still maintain our patients, see our patients, and in some areas they are the only providers available, so we need to keep them in our network so we look at their proposal and we work with them and try to come up with something mutually agreeable to both parties and that is presented to my boss with the information to get approval for that.
Q. How do you decide if it's agreeable to Empire?
A. That would be actually once I spoke to the group and we've mutually agreed to something, I would have to present that to my boss to see if that is something that the company would agree upon with the data that I have available and discussion with the doctor's office and the reasonings why we had to

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negotiate. They look at a lot of different variables and as for their decision, they may come back and ask more questions. They make the final decision on what I am presenting to them.
Q. What factors do you consider?
A. I consider -- the biggest factor I consider, to me, when I negotiate with the group is the member is if I don't have this doctor, what's going to happen to my patient and their satisfaction with the network, and that's my biggest consideration I look to do a negotiation.
Q. Would you agree to pay any price for a necessary component of your network?
A. No.
Q. How do you decide what price?
A. Usually a doctor's office will always come in high and be willing to negotiate down, and you work it out. You know they will come in that way, so you try to look at what they are doing, you get a rough idea where they want to go and you work on getting a proposal for them.

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Q. Have you ever engaged in negotiations, individual negotiations with providers about fee schedules where you failed to reach agreement?
A. I probably had a few small groups that it didn't get that far, it was determined up front that we just weren't going that way and we decided upfront before we got into actual negotiations, so we do get very few requests to do this.
Q. How did you determine that you weren't going to go that way?
A. The volume of members that they saw, the other providers available in their territory where they were close to other providers that could handle the patients and treat them. There are a lot of factors we look at to make the decision.
Q. Is it correct to say you determined that it wouldn't be worthwhile to pay more to those physicians with whom you didn't reach agreement?
A. No. I will let you go from there.

Q. Why were you unwilling to negotiate a separate fee schedule with some physicians?
A. Some of the providers would not even be willing to talk or negotiate, they he wanted to set a flat amount, which was unrealistic.
Q. Why was that unrealistic?
A. The percentage amount they were looking at was extremely high and I could not justify doing that percentage for them, so straight upfront, when we talked upfront, they said okay and they said this is it, they kind of said it is this amount or nothing, they made it clear to me upfront, so we said no, we can't do that, and so they said, okay, we are going to terminate.
Q. How do you know when you can justify the percentage they were asking?
A. Usually most offices are reasonable and they are fair in the percentages they ask for. You get an unreasonable office that asks for in excess of 150 percent of Medicare and they are not willing to talk. To me, that is

unrealistic to offer a doctor that much money when there are other providers in the same territory that are willing, that still see the patients and they see a higher volume than that physician's office.
Q. You are unwilling to pay a price that is not competitive?
MR. BENZA: Objection to competitive.
A. I don't consider it as a price that's being competitive. I think it's a price of more of an unrealistic request from an office.
Q. How do you know that the request is unrealistic?
A. Just my experience, just dealing with the requests I have done, just my experience in seeing it and the percentage that people ask for and how the context of the discussion goes.
Q. Are there any competitive dynamics associated with your negotiations with providers for individual fee schedules?
MR. BENZA: Objection.
A. Mainly my discussions for fee

schedules that we do are based, as I said earlier, are based on the network need and the product. We would like to keep everybody in our network, but there are times when we can't negotiate with people, it's not realistic.
Q. Because of a network need, do some providers have more leverage in negotiations with Empire?
A. Yes, some providers could have more leverage in those cases.
Q. Is that leverage important to determining the fees that are ultimately paid?
MR. BENZA: Objection.
A. In my experience in dealing with the provider that fits that criteria, they did approach me with something to that extent and they were actually very willing and they negotiated very fair on both parties, they did not use their leverage to strong hand us.
Q. How do you know that it's fair?
A. That's my, just the basis of my knowledge of what I thought they would have

asked for.
Q. What's your knowledge of what you felt they would ask for?
A. But knowing them being at only provider in a certain region, I would have thought they would have asked for a lot more than they did and a lot higher, knowing they had control of the market and the office actually took the approach of being very fair in their approach and they wanted to make some more money, but they were willing to work to get a mutual arrangement between the two, so based on that information, my experience.
Q. Did Empire pay that provider more than it pays its other providers?
MR. BENZA: Objection.
A. In that particular region, yes, they would be paying that doctor more than other providers.
Q. And the reason for that is that that provider was a necessary component in your network; is that right?

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A. Necessary to our network.
Q. In the cases in which you have negotiated separately with providers about fee schedules, were you approached originally by the provider?
A. Usually it's the practice administrator that approaches the insurance company.
Q. But it is not Empire that approaches the providers?
A. No.
Q. Approximately how many separate fee schedules have you negotiated during your tenure with Empire?
A. I know of three that I have negotiated full fee schedules.
Q. What do you mean by full fee schedules?
A. In some cases with some larger faculty practices or practices that we have had, they have done a full fee schedule, which is all the CPT codes, all of the medical codes and CPT

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listing.
Q. In those instances, did you separately negotiate about every CPT code?
A. A percentage was determined and that percentage was applied to all the CPT codes.
Q. Other than those three negotiations you have had about full fee schedules, have you had any other negotiations with providers about particular portions of the fee schedules?
A. Yes, we have.
Q. About how many?
A. Since I am new to my department upstate, I don't have all of the information for my department. I just know particularly what I did in my territory at the time that I can speak of, and I would say less than 10.
Q. Have any of the negotiations about CPT codes dealt with the codes for the administration of physician-administered drugs?
A. I don't recall that code coming up, but without going back, without remembering each one specifically, I couldn't definitely tell

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you, but I don't remember either of those two specific codes that I can think of on the lists.
Q. In the context of those discussions about particular CPT codes, how did you evaluate the value of the schedule change?
A. Again, I went back and I looked at the providers' claims data to see what they were submitting because they provided me with the particular codes, they gave me the particular codes they were looking for, and I worked with them on the particulars to reach an agreement.
Q. Going back and looking at the providers' claims data, did you try to determine how much more Empire was likely to be required to pay if it renegotiated the fee schedule?
A. Yes, I did.
Q. What did you do to determine that?
A. I would look at the codes that they were specifically requesting and I could see their frequency either from the time frame I was looking at and I could determine what we currently paid and what we paid in the

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negotiation, so I knew exactly what they would be getting.
MR. HOFFMAN: Excuse me, Clay, you are breaking up a little on the phone. If you could speak up, I would appreciate it.
MR. EVERETT: Sure.
Q. How did you balance those increased costs against the value of the provider in the network?
MR. BENZA: Objection.
A. At the time when I did those negotiations, I was a coordinator or the senior coordinator, I determined my network need and what my network would be like if I lost those providers and what access issues I would have for my providers in those networks, and when I presented that to my boss for approval, I presented that information to her with my information showing that if these providers left the network, this is what would happen to the network as the justification for that.
Q. Did you do any analysis of the

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competitive effects of having a provider missing from a network?
MR. BENZA: Objection.
A. I never really compared it to my provider network, my competitors' providers. I only specifically compared it to -- most of the negotiations are done for primary care physicians in areas, and I looked at if I lost that physician, where the patient could go, and if there was nothing available, that's what I based my analysis on.
Q. Were you concerned that if that provider was not included in the network Empire would lose some business?
A. I mean, anytime a provider wants to terminate, you are concerned that a member is going to be upset. I am not involved in the daily selling of the business, so my concerns are more for the members as an issue, because I always think, in our position, we are provider relations, but we deal with what the members have to access, so my concern is I want to be

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sure the member is happy. As for driving business, I don't look at that portion of it.
MR. BENZA: Would it be all right to take a couple minutes' break?
MR. EVERETT: That's fine.
(Recess taken.)
BY MR. EVERETT:
Q. Mr. Eddy, I am handing to you now a document that's been marked as Eddy Deposition Exhibit 3. It's a document bearing the Bates numbers EMP 13651 through EMP 13656.
Take a minute and look at that document.
(Exhibit Eddy 003, documents bearing production Nos. EMP 0013651 through EMP 0013657, marked for identification, as of this date.)
A. Okay.
Q. Have you had a chance to look at the document?
A. Yes, I have.
Q. Mr. Eddy, what is the preclinical

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policy committee?
A. It's a committee that makes decisions on medical policy for the company.
Q. Who are members of that committee?
A. Usually the members that make decisions on that are the medical directors in our company and then there is representation on the committee from various departments in the company.
Q. What departments are represented?
A. Our department is represented on it, and I am trying to think what else is.
There's somebody from medical policy and different staff members are there, and I can't think of the names of all of the departments, but there are provider services, different areas where they attend the meeting, listen to what's going on.
Q. Who is the representative from your department?
A. Actually, it is Paul Portsmore or myself.

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Q. How long has this committee been in existence?
A. As for the existence, I don't know when it actually started. I started attending this year when I was promoted.
Q. Prior to this year, you don't know whether it existed or not?
A. Prior to this year, I didn't know what the status was of the committee. I assume it's been in place. I just don't know what they have done, what they have done with that information.
Q. In the time that you have been a member of the preclinical policy committee, has there been discussion about prices paid for physician-administered drugs?
A. This document indicates that information on it and I have attended -- I probably started in March of this year attending the meetings on or off when my boss wasn't available.
Q. Have you attended any meetings where there has been discussion of prices for

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physician-administered drugs?
A. I don't recall if I was at this one in particular. Other meetings, I don't recall the information on it, because there are a lot of subjects they usually discuss.
Q. You don't recall if there has been any discussion of physician-administered drugs at meetings that you have attended?
A. That's correct, the meetings that I have attended, I don't recall, and I don't recall if I went to this meeting, actually.
Q. What topics are generally discussed at the meetings of the preclinical policy committee?
A. They will review medical policy for changes based on either requests from physicians by Empire's coverage of services and the medical directors review that information and present those topics.
Q. What do you mean by medical policy?
A. What they do is we have our current medical policy and a doctor may see MS, Medicare

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Services, pay something different than our policy at the time, so the doctor will send in information to our medical directors and they review their information they supply with information from the journals supporting that study and then our medical directors look at that information and make a decision if our policy should be updated or corrected.
Q. Do you include within medical policy decisions about prices?
A. Usually it's straight medical policy at this meeting, and just being at the meeting for a short time frame, that's what I have specifically seen with specific procedures, the policy decisions.
Q. By medical policy, do you include decisions about whether Empire will reimburse at all for a particular medical procedure?
A. They would look at information and some procedures are determined to be experimental and investigational which are not covered, and that's because of how the policy is

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set up for them, and it may affect if they are reimbursed or not.
Q. If you will look down to the second to last paragraph on the first page, the paragraph that begins "Drugs related to oncology," do you see that?
A. Yes.
Q. Have you ever negotiated separate fee schedules with any oncologists?
A. I would have to go back and look at those specific groups that we have full fee schedules to see if there are oncologists in the practices to see if they would be under the full fee schedules.
Some of the groups had them and then they have since changed their practice and they no longer have them in their groups.
Q. How would Empire find out about the provider objections to potential changes to Empire's medical policy?
A. Most likely that's from providers writing in to our medical director regarding

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concerns of current programs that are doing, what the company is doing about concerns if they add more to those programs or make changes to those programs.
Q. Are providers ever informed of potential changes in Empire's medical policies?
A. They are only informed once the change has been decided and approved. There's no prior notification of the change.
Q. In this context, do you have any understanding of how Empire came to understand that critical provider objections would be made by oncologists, urologists and rheumatologists for changing the basis for reimbursement for physician-administered drugs?
MR. BENZA: Objection as to the characterization of what the document says.
A. As for the document, I don't know what they have there that they reviewed other than what I have heard from my own providers.
Q. What have you heard from your own providers?

A. I have heard from the group that they were concerned because they buy from a particular vendor or a manufacturer directly and they wanted to continue going to that manufacturer because they were concerned about not getting the appropriate drugs or having their drugs, as they said, stolen in the mail when they were shipped to them, and that's the concerns that I have heard voiced to me from one practice.

Q. When were those concerns voiced?

A. Within the last two to four weeks we had a discussion.

Q. What gave rise to the discussion?

A. The doctors weren't happy with our current program and they wanted to let it be known to their coordinator and then I got involved with that.

Q. What is the current program?

A. Specialty Rx.

Q. Does page EMP 13651 the discussion under injectables refer to the Specialty Rx

program?

A. The second paragraph, there is a mention of Specialty Rx.

Q. Does the entire discussion talk about Specialty Rx?

MR. BENZA: Objection. The document speaks for itself.

MR. EVERETT: I am just asking for his interpretation.

A. To me, the notes just indicate what their response is to in that specific paragraph, what they are saying.

I mean, as for the context of what he is looking at, the rest of it, I don't know what was said in the discussion in the meeting.

Q. Are the rates that have been negotiated with Specialty Rx reflected in Empire's fee schedules?

A. As far as what I know that Specialty Rx is, there is a list of drugs that correspond to that program and if a patient requires those drugs, the patient or the provider would go

through Specialty Rx to obtain that drug and that's the only way that they could obtain the drug for our programs is through Specialty Rx. If the drug is not on a Specialty Rx list, the drug would be reimbursed at the AWP price that we have listed.

Q. Is the Specialty Rx price list incorporated in Empire's fee schedules?

MR. BENZA: Objection to incorporated.

A. I just answered that for you in the context that I said, I said the members have to go through Specialty Rx, so if they don't go through Specialty Rx and they buy it elsewhere, they don't use the program, the drug is denied, the doctor can't get payment from the patient because he didn't follow the guidelines of the program. So however you want to look at that you could say, if they don't utilize Specialty Rx, there is zero payment, there's nothing in the fee schedule. If they utilize it and get the approvals, it's going to be reimbursed according to those guidelines.

Q. Does Empire keep a fee schedule as a separate document?

A. For the drug codes, as I said earlier, it is based off of the AWP and always references AWP, depending on these programs, so it is not specifically in our fee schedule.

Q. If we turn now to the next page, 13652, first of all, having looked at this document, does it refresh your recollection at all as to whether you attended this meeting?

A. I still don't recall, looking at it. I mean, I would have to go back and check my calendar for the date just to verify if it was.

Q. Do you recall ever having discussions about non self-injectable drugs that are discussed in this document?

A. I have had discussions about Specialty Rx with people in my staff and different things like that, but as for the specifics of the other, I have not been involved in setting any change of reimbursement as what they are looking at here.

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Q. Are reimbursements for physician-administered drugs in the Empire system based on J codes?
A. It does look at the J code, but it also looks at the corresponding NDC code.
Q. Are there multiple NDC codes that correspond to individual J codes?
A. I know there's different dosage amounts under certain drugs. Offhand, I don't remember. I would have to look and see if there are separate NDC codes for each dosage amount, but there could be different dosages they use, but I can't remember if there is a separate NDC code for each dosage.
Q. Do AWPs vary based on NDCs?
A. AWPs can vary based on the dosages of the vials, there's different levels it can be.
Q. Are there separate NDCs based on the packager of the drug?
A. I don't know.
Q. How does Empire decide which AWP to use in reimbursing for physician-administered

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drugs that have assigned to them a J code?
MR. BENZA: Objection.
MR. HOFFMAN: Objection.
What do you mean by which AWP is used?
MR. BENZA: That is the basis for my objection as well.
A. Can you be more specific or --
Q. Do AWPs vary based on NDCs?
MR. BENZA: Objection. I don't think that is --
A. I am not well versed in the NDCs, because we usually refer the providers back to the drug topics book when they have questions, so the only time I would specifically go out to look and see if there is a specific code is if somebody questioned a claim and we were specifically looking at it to help them out.
Without looking at it there, I can't tell you if there's different levels for that portion of it, the NDC codes, I would specifically have to look at the system to see. I don't work with them every day, so I don't

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have that knowledge.
Q. You don't know whether AWPs vary based on the NDC code?
A. Right, since I don't work with it every day, I can't tell you that. If I looked on the system, I might be able to give you an answer.
Q. Is there an AWP published for each NDC code?
A. What I always follow is the drug topics book is whatever is listed in there, there's going to be the drug and the information, that's what it's going to relate to. That's how we relate that to the provider.
I don't get into the specifics of looking up the reimbursement for the pricing of them, to provide that, so I couldn't tell you.
Q. Are the listings in the drug topics book of AWPs listed by NDC?
MR. HOFFMAN: Objection.
Are you asking him his understanding or are you asking him to speak definitively

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on those books?
MR. EVERETT: I am asking for his understanding.
A. My understanding I have is ours is based on an Internet system at work and I can go in and type in a date, either a J code or NDC code and get information when a provider calls me with a question, so my experience in using it is just that system of what I am seeing. I don't have the actual book to look to see if it is different by other ways.
Q. In the system that Empire uses, you can type in a J code and that will pull up a particular AWP?
A. If the J code is an active code and it can go in, it will pull up the information. If not, you have to be more specific and indicate the NDC information on it. It all depends on the particular drugs.
Q. How do you determine the NDC for those products where typing in a J code won't pull up an AWP?

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A. I actually refer that back to the provider's office and ask them to give me a copy of the bill with the NDC code on it. I have no other way to determine that. They give me the actual code to look at and that's what I am following.

Q. On page 13652 the third to last bullet point before committee decisions indicates that therefore most of the claims are currently suspended from AWP pricing.

Do you see that?

A. Yes.

MR. BENZA: I am sorry, where is that?

Okay.

Q. Do you have an understanding of what manual pricing means?

A. Unfortunately, I have never processed claims of Blue Cross, so I can't tell you specifically what they do to process a claim manually, so --

Q. Do you have an understanding generally of what it would mean to manually price claims

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in the Empire system?

A. With this, I mean, just from my own thoughts here now thinking is if there are different doses of it, they would either probably have to contact the provider's office to get more specific information because different dosages could have different reimbursement levels and without having the correct dosage or knowing what that dosage is, they can't pay that claim correctly, so those may kick out to a person to review and either somehow either send the letter back or contact the office for more information.

Q. Why would different dosages have different reimbursement numbers?

MR. BENZA: Objection.

A. I honestly couldn't speak to that because I am not a pharmacist or doctor. I have noticed, looking at the codes, there are different levels, but I am not a medical person, so I couldn't tell you the difference of why one pays more on that. I just see the different

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codes out there.

Q. You have noticed that there are different prices or codes for different dosages; is that correct?

A. Yes.

Q. How does Empire decide what dosage to use in determining its reimbursement for physician-administered drugs?

MR. BENZA: Objection.

MR. HOFFMAN: Objection.

Q. You can answer.

A. Usually, from what I have heard from complaints through my coordinators is the provider has to supply an NDC code in addition to the J code when they send it in and that will point them to the correct payment to be paid.

Q. What is the medical cost forum?

A. I actually have not been involved in that, so I honestly couldn't tell you what they do.

Q. Are you aware that there is a group called the medical cost forum in Empire?

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A. Yes, I am. I have heard the name.

Q. Do you know generally what they do?

A. I actually -- I know they have meetings, but I don't know the specifics of their meetings, what the decisions are. I have heard the name, I just don't know what they actually do.

Q. Who is involved in the medical cost forum from Empire?

A. Since I haven't been involved, I don't know. I assume that that would be senior management, but I don't know who that would be, who those people would be.

Q. Why do you assume that that would be senior management?

A. Just that, to me, it is above me still that information, and it is not in my knowledge, has not been told to me, so I assume other people higher up are involved in that meeting.

MR. BENZA: Don't assume.

THE WITNESS: Sorry.

Q. Is anyone from provider relations

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involved in the medical cost forum?
A. I don't know.
Q. You mentioned previously that Empire at some point in the late 1990s changed its reimbursement for physician-administered drugs to AWP for its HMO products; is that correct?
A. Yes.
Q. Did Empire receive any complaints from providers when it made that change in pricing physician-administered drugs?
A. It's so long ago that I don't recall, I don't recall any complaints that I received or heard.
Q. Did any providers drop out of the Empire network due to the change in reimbursement for physician-administered drugs in HMO products?
A. I don't recall anything at that time, the providers withdrawing because of that.
Q. Mr. Eddy, I am going to hand to you now a document that's been labeled as Eddy Deposition Exhibit 4. This is a document

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bearing the Bates numbers E 28250 through E 28261.
Take a minute and look at that document.
(Exhibit Eddy 004, documents bearing production Nos. E 28250 through E 28261, marked for identification, as of this date.)
Q. Are you familiar with that document?
A. No.
Q. Was Empire entered into any contracts with specialty pharmacy providers?
A. The only information on that I know would be Specialty Rx.
Q. What is Specialty Rx?
A. That's the drug company that I indicated earlier that deals with handling certain drugs for Empire where the member would have to go through that vendor to obtain those drugs.
Q. When did Empire start working with Specialty Rx?

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A. I think, as I indicated earlier, I think that was in 2003. I don't have the actual time frame.
Q. What products are covered by the Specialty Rx contract?
A. If I recall correctly, that's the managed care products that we offer, but I would have to go back and look at the documentation just to make sure, to verify that.
Q. Does Empire offer any products that are not managed care products?
MR. BENZA: Asked and answered, objection.
A. We have some old indemnity products out there that have been out there forever that are not managed care.
Q. What is the basis for reimbursement in those products?
A. Some of the products are sold, I couldn't tell you. There is one product in particular upstate called Matrix and that is based on a percentage of Medicare RBRVS.

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Q. Are there other indemnity products besides that upstate New York product?
A. There are probably some other old ones that are small membership numbers, but I don't recall specifically their names.
Q. Do you know what the basis for reimbursement is under those indemnity products?
MR. BENZA: Objection.
A. I can only speak specifically as to Matrix, what the reimbursement is for that.
Q. You don't know what the basis is for reimbursement of the other indemnity products?
A. The other ones have been out there so long and are so old, we there probably very few or there isn't anybody on those anymore. I couldn't tell you what the specifics on those are anymore, we just don't see them that much.
Q. Does the contract with Specialty Rx relate to physician-administered drugs?
A. The contract with Specialty Rx relates to a list of drugs that's sent out with their mailing.

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Q. What drugs?
A. I don't know the specifics of what it would have been. The mailing sent to the providers would have told them specifically which drugs had to be Specialty Rx.
Q. Are all of the drugs that are part of the Specialty Rx list administered by physicians in their offices?
MR. BENZA: Objection.
A. I honestly couldn't tell you that because I don't know where the physician would utilize the drugs, if they utilized them in their office or elsewhere. I mean, there was information listed on the mailing, but as for the provider treating his patient, that's their decision where he sees the patient.
Q. Are they all physician-administered drugs?
A. Without looking at the names, knowing what they were, I couldn't tell you if they were all physician-administered drugs or not. I am not a physician so I wouldn't recall all that.

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Q. Turn to page E 28255 and look at the list that runs from page E 28255 through E 28259.
Are the drugs listed on those pages the drugs that are part of the Specialty Rx program?
A. I do not know. Without looking at the two and comparing, I couldn't tell you.
Q. What would you compare them to?
A. I would have to look at the mailing that was sent out to the providers with regard to Specialty Rx to see if they were the same drugs.
Q. You are only familiar with the mailing provided to providers?
A. Yes. This is not specific to my department, this document.
Q. Which department would have the responsibility for negotiating a contract relating to physician-administered drugs with a specialty pharmacy?
A. This contract here would most likely

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be handled by our pharmacy department.
Q. What changed when Empire began to use Specialty Rx?
MR. BENZA: Objection.
A. I honestly don't know what their reason, their decision was in that change.
Q. I am not asking why they changed. I am just asking mechanically what changed.
MR. BENZA: Objection.
MR. HOFFMAN: Same objection.
A. I still don't know what they did to that.
Q. You indicated that a mailing was sent out to physicians after Empire entered into a contract with Specialty Rx; is that correct?
A. Yes.
Q. What sort of information did that mailing provide to physicians?
A. It gave them an overview of the Specialty Rx program, a list of drugs, and it also gave them a document that they could fill out to either be faxed in or gave them -- I

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think the protocol was to call in and get approval for those drugs.
Q. What is the Specialty Rx program?
A. It's a program with a vendor that handles providing drugs that have been identified, certain drugs that have been identified, this vendor is the vendor that supplies them to providers or members.
Q. How is that drug provided to the providers or members?
A. Once the provider fills out the form and completes it, based on that information, either the drug is forwarded to the patient or the physician.
Q. Forwarded by --
A. Specialty Rx.
Q. Prior to the time that Empire had the contract with Specialty Rx, were drugs provided to providers or members of Empire's network by a specialty pharmacy?
MR. BENZA: Objection.
A. I do not know of anything in place. I

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don't know if there was because I am not on the pharmacy side to tell if there was something in place, but as far as I know, I don't recall anything other than Specialty Rx.
Q. Do you know why Empire decided to enter into a contract with Specialty Rx?
A. No, I do not.
Q. Did Empire solicit bids from specialty pharmacies other than Specialty Rx before entering into the Specialty Rx contract?
A. I don't know.
Q. Does Specialty Rx provide to providers in Empire's network any supplies other than the actual drugs?
A. I don't know.
Q. Does Specialty Rx provide to Empire any services other than the provision of drugs?
MR. BENZA: Objection.
A. Again, I don't know either.
Q. Does Empire have any preference as to whether drugs are administered in a hospital versus in a physician's offices?

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MR. HOFFMAN: Objection.
A. I don't know of any preference that they would have.
Q. To your knowledge, is it more expensive to Empire to have drugs dispensed to Empire's members in a hospital than in a physician's office?
A. Since I don't deal with the hospital contracting piece, I don't have any idea what the reimbursement would be there, so I really couldn't tell you if it would be higher or lower.
Q. In your job as regional director of provider relations, do you do anything to try to control Empire's costs of doing business?
MR. BENZA: Objection.
MR. HOFFMAN: Objection.
A. As regional manager for provider contracting, I don't have anything to do with the costs, controlling the costs, I am not involved in any way.
Q. In any of your previous positions were

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you involved in controlling costs?
A. No, I was not.
Q. Did Empire believe that providers were earning a margin on drugs that they dispensed to Empire's beneficiaries?
MR. BENZA: Objection.
MR. HOFFMAN: Objection.
A. I actually don't have any knowledge of that, I couldn't tell you.
Q. Other than the negotiations that you had with individual provider groups about particular changes to the fee schedule, do you have any responsibilities for setting Empire's reimbursement to providers?
A. I don't have any responsibilities with respect to reimbursement.
Q. Do you have any responsibilities associated with the reimbursement to physicians?
A. I may see a recommendation of what they are looking at to present, but I have no -- other than seeing what they are looking at, I have no piece of making that recommendation.

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Q. Who does that?
A. In our department, we are split up, each of us handle different avenues. One of my peers may be responsible to looking at the fee schedules and making recommendations to management, but I am not involved with that.
Q. By your other peers, you mean the other regional directors?
A. The other regional managers.
Q. In your meetings with the other regional managers, have you discussed the Empire fee schedules?
A. Yes, we have.
Q. Have you discussed Empire's policies for reimbursing physicians?
A. We've mainly discussed the fee schedules concerns that we hear from our provider network, that's what we've discussed.
Q. Is it just a free-ranging discussion of provider complaints?
MR. HOFFMAN: Objection.
A. In most cases, it is regarding, we are

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hearing questions from the providers in our community. That's pretty much what we base our discussions on, is what we are hearing coming in.

Q. Do you make decisions about reimbursement rates from physicians at those meetings of regional managers?

A. We have not.

Q. Do you make recommendations about reimbursement levels based on the discussions that are held at meetings of regional managers?

MR. HOFFMAN: Objection.

Recommendations to whom? Oral recommendations, written recommendations?

MR. EVERETT: I appreciate that.

Q. You can answer the question.

A. Currently I am not involved with the recommendations, so I have not had an opportunity yet to make a decision like that.

Q. Is that something that would be discussed in the meetings with regional managers?

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MR. BENZA: Objection.

A. It could be, it could be a topic.

Q. How do you know that it could be a topic?

A. If we have a meeting and one of my counterparts brings that topic up in a meeting, it could be discussed at the meeting, I mean, if they discuss it as an option that might be happening. Right now we haven't had that discussion, so I am not saying it would never happen, but it is something that could happen.

Q. Do you have agendas for those meetings?

A. We have not.

Q. Does Empire try to figure out providers' costs in setting reimbursement levels for providers?

MR. BENZA: Objection.

A. I haven't been involved in that, so I couldn't tell you if they do that or not. I mean, other than my negotiations, I haven't been involved in any other piece of that.

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Q. In your negotiations, do you try to figure out providers' costs in determining whether to offer reimbursement?

A. As I indicated earlier, mainly what we try to figure out is what their current cost is and what the future cost to be of the negotiation for the providers and that's what we do in the process.

Q. What do you do to determine their current costs?

A. We look at their claims volume for a particular period of time and compare that to the current fee schedule and then any change over that reimbursement would be the change the office is requesting that we are looking to negotiate.

Q. By provider costs, I mean the costs that are paid by the provider for overhead, for services, for products --

A. No.

MR. BENZA: Let him ask the question.

THE WITNESS: Sorry.

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Q. Do you try to figure out those provider costs --

MR. EVERETT: Strike that.

Q. Have you tried to figure out those provider costs in your negotiations with providers about fee schedules?

A. No, we have not. I wouldn't have knowledge of all the costs, what they are. We haven't discussed that.

Q. And you are able to reach some agreement with providers without knowing their costs?

MR. BENZA: Objection.

A. So far, in the majority of the cases, as I said earlier, the exceptions we have been able to come up with a mutually-agreed upon price in the negotiation.

Q. And those prices have been agreeable to Empire?

A. Yes, to both parties.

Q. Is Empire a Medicare carrier?

A. In what terms are you looking at as a

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Medicare carrier?
Q. Does Empire administer any Medicare products?
A. We have the senior plan HMO and we also are available as a secondary program that members can pick up in addition to Medicare.
Q. What is the senior plan?
A. The senior plan, it's an HMO program that is offered in, I want to say the lower eight or nine counties around New York City, and those members would choose a primary care physician to manage their care and then they would be able to see any doctor in the HMO network without a referral. Usually the members would have a copayment on their ID card that they would have to pay the primary care physician.
Q. Is that plan a Medicare Plus Choice plan?
A. I am not familiar with it because it's not in my territory, it's only down here, so since it is not in my territory, I don't look

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through all of the information, so I am not 100 percent sure if it is. Since upstate we can't offer it, I am not versed in the whole program, what it is.
Q. Does Empire have separate negotiations with providers about reimbursement for its senior plan?
A. Senior plan, as far as I know, is reimbursed the same as the other HMO products, there is no different reimbursement.
Q. Does the senior plan cover physician-administered drugs?
A. I don't know the actual benefits of the program, so I really can't give you a definite answer on that. It's an HMO program, but I don't know the actual benefits on the program.
Q. Does Empire receive circulars from the centers for Medicaid and Medicare services?
MR. BENZA: Objection to circulars.
A. More specific can you tell me? I am not sure if we do receive those.

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Can you be more specific?
Q. Does Empire receive information from the centers for Medicare and Medicaid services?
MR. BENZA: Objection.
A. Again, I don't know. There is a specific area that deals with the senior plan in the company, I mean, that deals with managing of the program, so I don't know what they receive, what they get in that aspect of it, so I really can't answer that for you.
Q. Do your duties have anything to do with Medicare?
A. With senior plan, no. Medicare secondary, sometimes we get those, there's a lot of patients that have secondary Medicare.
Q. What is Medicare secondary?
A. Usually it is a supplemental policy that the member purchases from Empire Blue Cross and they have a deductible to be met, and then what happens is when Medicare does not pay the 20 percent, the 20 percent that is not covered rolls over to Empire. We will then process the

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claim and pay that according to that plan. We would pay 80 percent, the member has a 20 percent responsibility or they could have a deductible. It is all what their benefit is at that time, what they have met.
Q. If you combine the member's copay and the payments made by Empire as part of this Medicare secondary program, is the full amount of the leftover Medicare payment paid?
MR. BENZA: Objection.
MR. HOFFMAN: Objection.
A. It could vary and that is a hard question to answer, because depending on the service rendered, I mean, is it something that Medicare covers or not, I mean, and the other aspect, when you look at the deductibles, the coinsurance and things, there's a lot of factors in there that it may not add up, so --
Q. For some services Medicare requires beneficiaries to make a 20 percent copayment. Are you aware of that?
A. Yes, I am.

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Q. Does the -- in the cases where Medicare requires the beneficiaries to make a 20 percent copayment, does Empire's secondary Medicare coverage apply to pay for any of those copayments?

MR. BENZA: Objection.

MR. HOFFMAN: Objection.

A. The coverage will most likely be based on the member's benefit, the member's contract, and that will depend what gets paid, the particular groups, I mean, whatever their policy is.

To answer that, it is not -- I mean, you really can't tell without looking, there isn't a definite answer.

Q. Is the Medicare copay one of the things that's covered by the secondary Medicare policies offered by Empire?

MR. BENZA: Objection.

A. Again, it's a coinsurance for Medicare that crosses over and the member could still be responsible for a portion of that, and without

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seeing a claim, an actual claim process, there is not a definite answer I can tell you yes, it would cover it all the way or not all the way.

Q. I am not asking you if it is covered all the way or not covered all the way, just whether it is in any cases covered at all.

A. That 20 percent coinsurance, when it crosses over, could be covered and paid. I mean, without seeing the actual patient and that information, what was billed, I couldn't tell you that it's always going to happen that way.

Q. What do you mean by --

A. Something may come over, they may still have a deductible they owe, so we wouldn't make any payment, but the patient would be responsible. So, I mean, not knowing all of the factors, there is not really a definite answer that I can tell you yes we would pay or Empire wouldn't pay in those cases.

Q. That is not my question. The question is whether they would ever pay.

MR. BENZA: Objection.

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A. Again, it's the same thing back again. I really can't give you a definite, a specific.

Q. What are the factors that play into that?

A. If the member's deductible has been met, the policies or services that are being billed. There are lots of things that come into effect when a claim comes across that may not always -- when you think about it, yes, it may pay, no, it may not pay, and again, it is not getting back -- there are lots of factors that could influence the way, if it could do what you are asking it to do.

Q. Let's assume a situation where the Medicare deductible has been completely paid, the service is covered by Medicare, there is a 20 percent copayment. The member has a policy with Empire for a secondary Medicare coverage.

In that circumstance, would Empire pay a portion of the copayment?

MR. BENZA: Objection.

MR. HOFFMAN: Objection.

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A. Again, it is specific. We could pay a portion of that, they could be responsible. I actually don't know without seeing the claim.

Q. Is the secondary Medicare coverage offered by Empire an indemnity program?

MR. HOFFMAN: Objection.

A. It does meet the criteria of an indemnity program because the member, in essence, can see whoever they want to see, they are not restricted for referrals or stuff like that, so technically, you could say yes, it could be considered an indemnity program.

Q. Are the terms of Empire's reimbursement to providers for its secondary Medicare coverage determined by reference to Empire's fee schedules?

MR. BENZA: Objection.

A. Claims for patients with secondary is referenced back to what Medicare approves. When it rolls across to us, we can pay up to the Medicare approved amount, depending upon the services of the contractors, a lot of factors,

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but we look at the Medicare approved amount on our fee schedule.
Q. You indicated that you can pay up to the Medicare amount.
In what cases would Empire pay less than the Medicare allotment?
A. If for some reason a claim came across that we did not make any payment, the patient had the responsibility, we, in essence, did not make any payment, the member is paying the difference up to that, so the member is going to get billed by the provider up to that Medicare amount, it is based on what their benefit is with us on the claim, if we pay that amount or not.
MR. BENZA: Could we take five?
MR. EVERETT: Let's go off the record.
(Recess taken.)
BY MR. EVERETT:
Q. Mr. Eddy, does Empire employ any physicians?
A. We have medical directors on staff.

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Q. Are there any physicians in the provider contracting division?
A. In what context are you looking, in our department, I mean, or more specific or --
Q. Just whether there are any physicians in the provider contracting department.
A. The only one that I -- there is Dr. Wolinsky who does medical policy, and I don't know where he rates, which department he is actually linked to for you, and then the -- I can't think of what his title is, but there is Dr. Sokolow who is the head of our division. Other than that, I don't know of any other physicians. I just don't know where Dr. Wolinsky fits in, if he is in another area or what.
Q. Dr. Sokolow is the head of what division?
A. He is in charge of the managed care area, but I don't know what his actual title is.
Q. Did Dr. Sokolow ever have a clinical practice?

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MR. BENZA: Objection.
A. I don't know.
Q. Do you know if Dr. Wolinsky ever had a clinical practice?
MR. BENZA: Objection.
A. I don't know either.
MR. EVERETT: What is the basis for that objection?
MR. BENZA: You are going to have Dr. Wolinsky here.
MR. EVERETT: That doesn't make the question objectionable to him.
MR. BENZA: Also, you know, lack of foundation.
It's okay, he can answer. I didn't instruct him not to answer.
Q. You testified earlier that you believed AWP referred to the prices paid by providers to purchase drugs from manufacturers; is that correct?
A. I think the word that I probably -- I think I said earlier was AWP is the price that

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the manufacturer sets for the cost of the drug. It's not the price -- it's what the manufacturer sets the price as, I think is what I said.
Q. How is that different from the price that's paid by the provider?
A. The provider has to pay what the manufacturer sets, so depending upon how you look at it, I mean, in my context, I just said what the manufacturer set. As far as I know, the provider can't say I am only going to pay you this amount of money, they have to pay what the manufacturer says.
Q. Do you believe that there is any difference in terms of percentage between AWP and the prices that providers pay?
A. To me, it should be the same, as far as I know.
MR. EVERETT: Mr. Eddy, I have no further questions for you right now.
Are there any questions from any of the other defense counsel on the phone?
MS. KILLOREN: I have nothing.

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MS. SCHLESSLER: I have nothing.
MR. HOFFMAN: Plaintiffs' counsel will have some questions.
If we could, can we take a five-minute break, we will come back?
MR. BENZA: Fine with us.
MR. HOFFMAN: Okay.
(Recess taken.)
EXAMINATION BY
MR. HOFFMAN
Q. Good morning, Mr. Eddy. I am Allan Hoffman, attorney for the plaintiffs.
A. Good afternoon.
Q. I just had some questions concerning your earlier testimony, some follow-up questions.
First, you testified earlier that the original fee schedule that was set up in 1994 for Empire was at 125 percent of Medicare.
Do you recall that?
A. Yes, I do.
Q. When you said Medicare in that

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context, were you talking about the Medicare part B fee schedule?
A. We base our fee schedule off of Medicare RBRVS.
Q. Can you describe that?
A. Medicare has reimbursement for physicians and they have a relatively based relative value system they use to calculate a reimbursement price and we use that value they calculate as a basis for our fee schedule.
Q. Is that an AWP-based system?
A. I would say it's probably not. I mean, Medicare comes through some type of -- I don't know what their mechanism is for creating their fee schedule, but most everybody bases their fees in some form or way off of Medicare.
Q. Is it possible Medicare, that the Medicare system is an AWP-based system and you are just not sure?
A. AWP-based, my understanding is that is a price set by the manufacturer. Medicare sets its price, but I don't know what format they use

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to set that. I can't speak specifically to how Medicare creates their schedule.
Q. You spoke about contracts that were, that referenced managed care, the managed care fee schedule.
Do you recall that?
A. I remember speaking about the managed care contracts, yes.
Q. You had said that it doesn't specifically reference AWP, but it is AWP based in the fee schedule; is that right?
MR. EVERETT: Objection to the form.
A. The managed care agreement references in a section of it the managed care fee schedule as the reimbursement to a provider. It does not have any mention in that document about AWP at all, it just references straight managed care fee schedule.
Q. But the fee schedule has always been AWP based; is that correct?
A. Yes. As far as I recall, from when I have been in the department until now, it's

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always been AWP-based, that is correct.
Q. Has it always been the contract that was in place or is there another type of contract that preceded that?
A. Since I have been in the department, it's always been AWP-based. I don't have any other knowledge that it wasn't based off of that.
Q. And the fact that it references managed care fee schedule, did the contracts before that reference AWP specifically, do you know?
A. I don't recall anything in specific contracts.
Q. The drugs that are purchased through Specialty Rx you spoke about earlier, do you recall that?
A. Yes.
Q. Those drugs are purchased based on an AWP-based formula; isn't that correct?
MR. EVERETT: Objection to form.
A. I don't know the specifics of the

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pricing behind Specialty Rx and how that is set up. I know of the program and the protocols of how the provider or the member have to go about obtaining the drugs, but I don't know specifically the reimbursement methodology beyond that.

Q. Would you look at Exhibit 4, what was marked as Exhibit 4 earlier.

A. Yes.

Q. Turning to Exhibit 1 --

MR. EVERETT: Exhibit 1?

Q. Turn to Exhibit 1 within that contract, the drug addendum.

A. Yes.

Q. Do you see that has ingredient costs, AWP discount.

A. I see that on the document.

Q. Does that refresh your recollection as to whether or not this contract is reimbursed in an AWP-based system?

A. This contract is specific to the pharmacy department, it's not my department, so

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I don't have knowledge of what they did when they wrote that, so I really couldn't tell you the specifics of how that works.

Q. You don't know one way or the other?

A. No. I would leave that to them to provide that answer. I don't have the definite answer on that.

Q. Is it your understanding that other than when applying a usual or customary amount that the reimbursement for drugs under the Empire plan's providers are AWP-based?

A. The usual and customary amount I referenced earlier I referenced specifically to providers and medical services.

As for the drug services and reimbursement, I am not involved in the actual pricing of those drugs, so I couldn't tell you the usual and customary effect of the drugs, only the provider piece of the business.

Q. How about on the services side?

A. On the services side, for a provider if he is billing for an office visit or another

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service and he is nonparticipating, the fees, the service would be looked at according to the usual and customary fee schedule and reimbursed that way.

Q. When it is not based on usual and customary fee schedule, what is that based on?

A. It's based on if it is a managed care account, it is based on a managed care fee schedule.

Q. Which is AWP-based; is that correct?

A. Yes.

Q. What is Empire seeking to cover when it reimburses physicians based on AWP?

A. Could you clarify that?

I am not sure I understand what you are looking for.

Q. When they set up the system to cover based on AWP, what is it they are seeking to cover for the provider?

MR. BENZA: Objection to it. It what?

MR. HOFFMAN: I am sorry, who made that objection?

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MR. BENZA: I did. You said it, and I am just wondering what the it is that you reference there.

Q. I don't know exactly what I said.

What is Empire seeking to cover in reimbursing physicians based on AWP?

Do you understand that question?

A. It's my understanding that AWP is the price that the doctor is purchasing the drug for, it's what he is paying for the drug, so my understanding of that is we are reimbursing the provider for what he's spent on the drug.

Q. Okay.

Does Empire view its reimbursement rate for physician-administered drugs as an opportunity for manufacturers to mark up the cost of drugs?

MR. EVERETT: Objection.

A. I can't really answer that because I don't really know. I have always -- I always have thought that the AWP is the actual price, so I don't have any knowledge of that.

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Q. Right. But my question is, does Empire choose to reimburse drugs -- does it choose its rate for reimbursement with the intention of it being an inflated cost of a drug or inflated AWP?
MR. EVERETT: Objection.
A. I have no knowledge of the inflated AWP, so I really can't answer that.
Q. Let me ask that another way.
Is it important for Empire that AWP prices be as accurate as possible?
MR. EVERETT: Objection, foundation.
A. I have always thought the AWP price was the price that was the accurate price.
Q. Right. Is that important to Empire that it be the accurate price?
MR. EVERETT: Same objection.
A. I would say yes, it would be important if it's the price.
Q. Why is that?
A. Because I want to make sure that I'm reimbursing my providers fairly for a service.

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Q. Would knowing that a drug's AWP was substantially higher than what the physician is paying for the drug affect the amount Empire would pay to reimburse the physician?
A. I don't know. I really couldn't answer that. I mean, everything that I know, all of my knowledge that I have is based on AWP being the actual price, so I have no knowledge to believe that it's not the case.
Q. Is it fair to say that Empire would prefer to use a noninflated AWP benchmark as opposed to an inflated benchmark?
MR. EVERETT: Objection.
A. I am actually not the person who makes that decision, so I don't know.
Q. What's your understanding?
MR. EVERETT: Same objection.
I don't know what you mean by inflated.
A. I am still not sure where you are going with the question, so I --
Q. Okay. My question is a simple one.

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I was just asking whether Empire would prefer a noninflated AWP benchmark as opposed to learning that the AWP is an inflated benchmark and is not tied to prices or an average of prices.
MR. EVERETT: Objection.
A. My only knowledge of the whole topic is what I read in the complaint, so I really can't provide an adequate answer because I have not done any research into that information, even to review it to see if there is an issue there, so I don't feel -- I don't have a decision that I could say, provide you with an answer.
Q. Let me ask you this: Would Empire be interested in negotiating prices from a benchmark that is as accurate as possible?
MR. EVERETT: Objection.
What do you mean by accurate?
A. Could you be more specific?
Q. Well, when you go about setting reimbursement rates and you said that is an

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AWP-based system, isn't it important to Empire that the AWP benchmark be accurate?
MR. EVERETT: Objection.
A. It's my knowledge right now that the AWP system is the accurate number that we're using. Since I have not done any research or seen any other research, it's hard for me to say another way that it's inaccurate. I would have to see stuff to know. Right now I don't know that information.
Q. Right. You testified earlier that you would want it to be accurate because you would want to know that your reimbursement system was the right amount to be paying providers.
MR. EVERETT: Objection, mischaracterizes his testimony.
MR. BENZA: You can answer his question.
Q. Is that correct?
A. I would like it to be accurate --
MR. BENZA: Really, it's yes or no.
A. Yes, it should be accurate.

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MR. BENZA: That's what he was asking you.
Q. Okay.
A. I want it to be accurate, I mean, I want it to be accurate, but right now, just with what my knowledge is, I have no belief that AWP isn't accurate. So I don't know that other than what I have seen and heard in the complaint.
Q. I am not asking you what your knowledge is. I am just asking whether that is an important factor for you and your answer was yes?
A. Yes.
Q. You spoke earlier about certain J code drugs and I just want to clarify for my understanding, did the J code drugs include AWP drug cost and an administration fee?
A. Administration fees can be paid on the drugs. I couldn't tell you specifically which drugs it is or is not, I mean, that would probably look at policy to see if there were a decision not to allow administration for certain

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drugs, but if it is allowed, we could pay a J code and a corresponding admin fee to the provider.
Q. Is the drug cost itemized in those circumstances?
A. When the provider bills on those claims, he would bill for the drug with the J code and include the NDC and then bill the admin cost additionally.
Q. Okay. So you would view it to determine what the AWP cost was in that case, separate from the administration fee?
A. Yeah, you would have to go back over a claim and look at a claim and actually see and identify the claims, but they are two different lines, the doctor has to bill separately.
Q. Returning back to the U&C in the medical service environment, would you agree that U&C is not frequently used as a basis for payment in those settings?
A. Yes.
Q. If it is not a U&C basis for payment

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for brand drugs, it would be an AWP-based payment?
MR. EVERETT: Objection.
A. We have a very large provider network, so, yes, it would be paid under the AWP.
Q. Now, you were talking earlier about alternative fee schedules that are negotiated with practices, with provider practices. You had said you negotiated three that you are aware of alternative full fee schedules and less than 10 partial fee schedules.
Do you recall that?
A. Yes, I do.
Q. Okay. And just to put it in perspective, how many provider practice contracts have you negotiated that did not involve alternative fee schedules, can you approximate that?
A. I would probably say overall, I mean, 85 -- at least 85 percent to 95 percent of my providers are on standard fee schedules.
Q. Has that always been the case?

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A. Yes.
Q. The senior plan you referred to, is that also an AWP-based reimbursement for the drugs on that plan?
A. I don't know specifically since I don't deal with it up in my territory, I don't know the specifics of that program.
Q. So you don't know either way?
A. It's an HMO-based program, but I am not a definite, I don't have a definite answer.
Q. Who would know the answer to that?
A. We would probably have to talk to somebody that is in that area. I mean, I would say -- I would more lean to yes, it is an HMO-based reimbursement, but I am not 100 percent sure on that.
Q. Let me ask you one last question.
Would Empire want to know if AWPs were inflated?
MR. EVERETT: Objection.
MR. BENZA: That's a yes or no.
A. I would say yes.

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Q. Why is that?
A. If the pricing was -- if we were paying more than we should have, I would say, as a company, we would want to know that.
Q. Why is that?
A. Because the price that we are going by, the benchmark, the AWP then wouldn't be correct, so that would be something that we would probably want to look into.
Q. Would that knowledge be used in determining reimbursement rates by Empire?
A. It could be.
MR. HOFFMAN: Those are all of the questions that I have.
MR. EVERETT: I just have a couple of questions to clarify a couple of things you just said.
BY MR. EVERETT:
Q. Just to be clear, Empire doesn't reimburse for any medical services or procedures based on AWP, does it?
A. No. The medical services are based on

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our fee schedule.
Q. I know you testified about this previously, but is there a document that is the managed care fee schedule?
A. There is not an actual document. It's actually, to print every code off you would have huge piles of paper. It is actually on our system, we have to pull down codes as doctors request them.
Q. Does that system make any direct reference to AWP?
A. When a claim comes in, I don't know how it truly processes on the system, how it gets that price. It is somehow directed over to the system where the AWPs are housed, but I don't know exactly how that works behind the scenes.
Q. I believe you testified a moment ago that if payments for physician-administered drugs are not made at usual and customary, then they are made at some AWP-based price by Empire; is that correct?

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A. If the drug, as you stated, comes in from a non-par provider, it looks at the U&C. If it is a par provider, it would pay according to our fee schedules again. It looks at our fee schedules and then if it is a drug, it would go out to the AWP and process according to that.
Q. If the provider billed Empire less than the AWP-based price that Empire was willing to pay, would Empire pay the billed charge?
A. Yes.
MR. EVERETT: I don't have any other questions.
I think we are done.
BY MR. HOFFMAN:
Q. Are you aware of an instance where that's occurred?
A. I have not seen an instance where that occurred, but if the providers bill less than our fee schedule, we will pay them as what they bill us.
Q. You are unaware of that ever occurring, though; is that correct?

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A. I have not seen it occur.
MR. HOFFMAN: Okay.
Do you have any further questions, Clay?
MR. EVERETT: No, I don't.
MR. BENZA: Thank you all very much.
(Time noted: 4:04 p.m.)

CERTIFICATE

STATE OF NEW YORK)
: ss.
COUNTY OF NEW YORK)

I, CARY N. BIGELOW, RPR, a Notary Public within and for the State of New York, do hereby certify:

That CHRISTOPHER EDDY, the witness whose testimony is hereinbefore set forth, was duly sworn by me and that such testimony given by the witness was taken down stenographically by me and then transcribed.

I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 6th day of October, 2004.

_____
CARY N. BIGELOW, RPR